

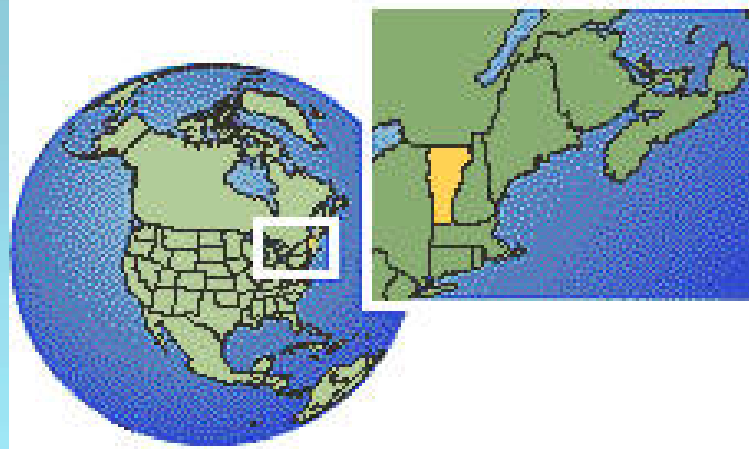
Vermont Health Care Reform of 2006

November, 2006

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Vermont Context



- Population: 620,000
- 19 U.S. cities are larger than Vermont
- Ranked the 2nd healthiest state overall in 2005
- Ranked 2nd for proportion of population insured

Vermont Context – The Insured

■ Private Health Insurance

- 59.4% (370,000) have private insurance as primary coverage
 - 91% receive employer-sponsored insurance
 - 5% purchase their own coverage in the individual market
 - Remaining covered by higher education, COBRA, etc.

■ Medicaid:

- 14.5% (90,350) have Medicaid as primary coverage
 - Traditional Medicaid – up to 125% FPL
 - Dr. Dynasaur – Children in households up to 300% FPL (34% of Vermont's children)
 - Vermont Health Access Plan (VHAP) – Adults up to 150% FPL and caretakers of dependent children up to 185% FPL

- Largest Insurer in Vermont (9,000 Enrolled Providers)

- Medicare: 14.5% (90,100)

- Military Insurance: 1.7% (10,500)

Vermont Context – The Uninsured

- 9.8% of all Vermonters (61,000)
 - 4.9% of Vermont children (6,940)
 - 51% are eligible for Medicaid programs but not enrolled
 - 27% have household income between 150-185% and 300% FPL and are not eligible for a Medicaid program
 - Of working uninsured adults:
 - 60% work full-time
 - 30% work for employers that provide health insurance benefits
 - 69% have been without insurance for more than a year

Vermont Context – Health Care Costs

- Annual expenditures of \$3.3 billion
- 14.7% of Vermont's gross state product
- Per capita costs still less than national average, but
 - ... Spending growth rates have been higher than national average for last 6 years
- \$9,483 = average family premium for coverage (2004)
- An estimated 25% of Vermonters with chronic conditions account for 70% of health care spending, but only 55% get the right care at the right time

Vermont's Response

- 2006 Legislation
 - Health Care Affordability Acts (Acts 190, 191)
 - Common Sense Initiatives (Appropriations Bill)
 - Sorry Works! (Act 142)
 - Safe Staffing and Quality Patient Care (Act 153)
- Joint Legislative Commission on Health Care Reform
- Administration Director of Health Care Reform Implementation

Health Care Reform Goals

Increase Access

Improve Quality

Contain Costs



Goal: Increase Access to Affordable Health Care Coverage

Enhance Private Insurance Coverage

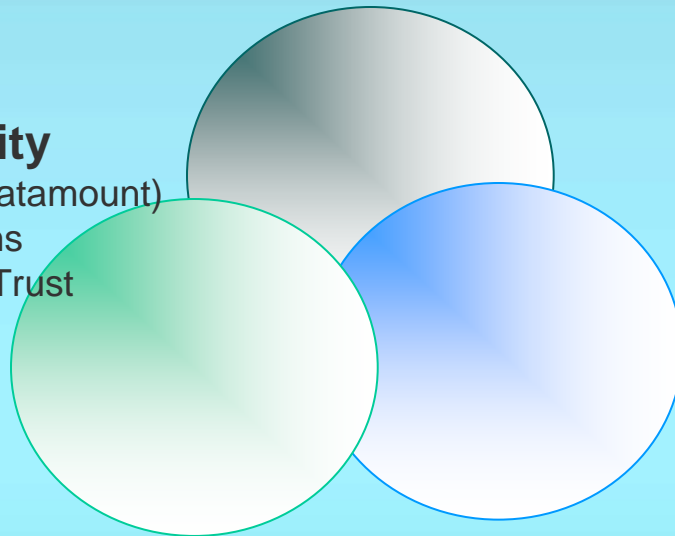
- Catamount Health Plan for the Uninsured
- Non-Group Market Reform
- Promotion of Employer-Sponsored Insurance
- Local Health Care Coverage Planning Grant
- Potential Individual Insurance Mandate

Assist with Affordability

- Premium Assistance (ESI, Catamount)
- Reduction in VHAP Premiums
- Non-Group Market Security Trust

Improve Outreach to Uninsured

- Toll-free Help Line
- Aggressive Marketing



Goal: Improve Quality of Care

Chronic Care Management

- Expand Blueprint Statewide
- OVHA Chronic Care Management Program
- Medicaid Reimbursement Incentives
- State Employee Health Plan
- ESI Premium Assistance plan approval, cost-sharing
- Catamount Health coverage, cost-sharing
- Chronic Fatigue Syndrome Information

Increase Provider Availability

- Loan Repayment Program
- Loan Forgiveness Program
- FQHC Look-alike Funding
- Uncompensated Care Pool

Promote Quality Improvement

- Consumer Health Care Price & Quality System
- Multi-payer Database
- Adverse Events Monitoring System
- Hospital-acquired Infections Data
- Safe Staffing Reporting
- SorryWorks!
- Advanced Directives

Increase Provider Access to Patient Information

- Health Information Technology
- Electronic Medical Records
- Master Provider Index

Promote Wellness

- Immunizations
- CHAMPPS Grants
- Catamount Health Coverage, cost-sharing
- Healthy Lifestyles Insurance Discounts
- AHS Inventory of Health and Wellness Programs

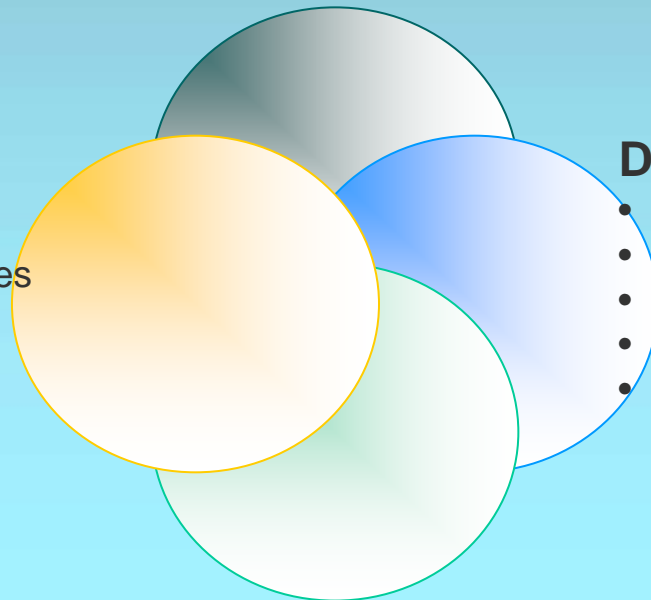
Goal: Contain Costs

Increase Access to Coverage and Care

→ Decrease Uncompensated Care → Lower Premium Costs

Simplify Administration

- Common Claims and Procedures
- Uniform Provider Credentialing



Decrease Cost Shift

- Increase Medicaid Provider Rates
- Cost Shift Task Force
- Standardize Policy for Hospital
- Uncompensated Care and Bad Debt
- Hospital Cost Shift Reporting Reforms

Improve Quality of Health Care

→ Appropriate Care → Lower Costs

Insurance Coverage

Catamount Health

- A non-group insurance product for uninsured Vermont residents
- Offered as a preferred provider organization plan by private insurers, beginning October 1, 2007
- Is required to be a comprehensive insurance package covering:
 - Primary care
 - Preventative care
 - Acute episodic care
 - Chronic care
 - Hospital services
 - Pharmaceutical coverage
- Individuals may choose which insurer they would like to use.

Catamount Health

- The cost of Catamount Health will depend on your income and which insurer you sign up with.
- For the least expensive plan, Catamount Health will cost:

Income by federal poverty level

(1 person/annual in 2006)

- Below 200% FPL (\$19,600)
- 200-225% (\$19,600 – 22,050)
- 225-250% (\$22,050 – 24,500)
- 250-275% (\$24,500 – 26,950)
- 275-300% (\$26,950 – 29,400)
- Over 300% (\$29,400)

Monthly premium cost

\$60.00
\$90.00
\$110.00
\$125.00
\$135.00
Full cost, estimated at \$340.00

Catamount Health

LEGISLATIVELY-MANDATED COST-SHARING

- **Deductibles:**

<u><i>In-Network:</i></u>	<u><i>Out-of-Network:</i></u>
\$250/individual	\$500/individual
\$500/family	\$1,000/family
- **Co-Payment:** \$10/office visit
- **Prescription Drugs:**
No deductible
Co-payments: \$10 generic drugs
\$30 drugs on preferred drug list
\$50 non-preferred drugs
- **Preventive Care & Chronic Care*:** \$0 Not subject to deductible, co-insurance, co-payments
- **Out-of-Pocket Maximum:** *(excluding Premium)*

<u><i>In-Network:</i></u>	<u><i>Out-of-Network:</i></u>
\$800/individual	\$1,500/individual
\$1,600/family	\$3,000/family

* For people enrolled in Chronic Care Management Program

Catamount Health

■ PROVIDER REIMBURSEMENT

- Health Care Professionals: Medicare +10% in 2006, increasing as per Medicare reimbursement methodology
- Hospitals: Cost +10%, increasing as per Medicare economic index

■ OVERSIGHT

- Insurers go through the usual rate-setting process at the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)
- Emergency Board will suspend enrollment in Catamount Health premium assistance if there is not enough money
- Commission on Health Care Reform to review Catamount Health Plan by October 1, 2009 for cost-effectiveness → may trigger a self-insured plan if current structure is not cost-effective

Catamount Health Eligibility

- You can purchase Catamount Health if you are an ***uninsured*** Vermont resident, are 18+, and are not eligible for an Employer-Sponsored Insurance (ESI) plan *.

Uninsured means:

- You have insurance which only covers hospital care OR doctor's visits (but not both)
- You have not had private insurance for the past 12 months
- You had VHAP or Medicaid but became ineligible for those programs
- You had private insurance but lost it because you:
 - ✓ Lost your job
 - ✓ Got divorced
 - ✓ Finished with COBRA coverage
 - ✓ Had insurance through someone else who died
 - ✓ Are no longer a dependent on your parent's insurance
 - ✓ Graduated, took a leave of absence, or finished college or university and got your insurance through school

Catamount Health Eligibility

- You can purchase Catamount Health even if you are eligible for an Employer-Sponsored Insurance (ESI) plan IF you have an income under 300% FPL, AND

Your ESI plan is not approved by the state as comprehensive and affordable (with state assistance)

OR

It is more cost effective to the state to provide premium assistance for you to enroll in a Catamount Health plan than providing premium assistance for you to enroll in your ESI

OR

It is more cost effective to the state to provide premium assistance for you to enroll in your ESI than providing premium assistance for you to enroll in Catamount Health, but you must wait until the next open enrollment period for your ESI (at which point you must switch to your ESI to receive premium assistance)

Key Dates

■ CATAMOUNT HEALTH

- | | |
|--------------------------|--|
| September 8, 2006 | Rules filed with Secretary of State |
| October 7, 2006 | Carriers submitted Letters of Intent (BCBS-VT, MVP, CDPHP) |
| Mid-March, 2007 | Carriers file forms and rates |
| October 1, 2007 | Catamount Health Insurance available to Uninsured Vermonters |
| October 1, 2009 | Legislative review re: Cost Effectiveness; may trigger a self-insured plan |

Premium Assistance

- Employer-Sponsored Insurance (ESI)
 - Uninsured Vermonters with income less than or equal to 300% FPL may apply for ESI premium assistance
 - ESI plans must offer comprehensive benefits in order for the individual to receive premium assistance
- Catamount Health
 - Vermonters who qualify for Catamount Health with income less than or equal to 300% of Federal Poverty Level (\$29,500 for one person) may receive premium assistance from the state

Premium Assistance

Cost Effectiveness Test

- **VHAP Applicants (under 150 -185% FPL)**
 - If providing premium assistance to the individual to enroll in their ESI plan is more cost-effective to the state than enrollment in VHAP, the applicant will be required to enroll in their ESI plan to get state assistance.
- **Catamount Health Applicants (at or under 300% FPL)**
 - If providing premium assistance to the individual to enroll in their ESI plan is more cost-effective to the state than providing premium assistance for the Catamount Health Plan, the applicant will only receive state assistance to enroll in their ESI plan.

How will Premium Assistance be Paid?

■ Catamount Health Premium Assistance

- Beneficiary will pay his or her share to state
- State will pay total premium to carrier

■ ESI Premium Assistance

- Employee will pay total premium to employer through payroll deduction
- State will pay employee prospectively for premium assistance
- Employers will not have to modify payroll or accounting systems
- Employers may have to provide information on the plan's cost to the employees to assist with enrollment in the premium assistance program

Key Dates

■ PREMIUM ASSISTANCE FOR ESI/CATAMOUNT

- | | |
|------------------------|---|
| September, 2006 | Waiver Amendment Request submitted to CMS for approval of premium assistance programs |
| November, 2006 | Report to Legislative Committees on Fiscal Implications (estimated costs and savings) |
| February, 2007 | Draft Rules for Premium Assistance Eligibility Determination |
| July, 2007 | Finalize Rules for Premium Assistance Eligibility Determination |
| October 1, 2007 | Premium Assistance available for ESI and Catamount to Eligible Vermonters |

Other Initiatives to Enhance Private Insurance Coverage

- Non-Group Market Reform and Trust
- Promotion of Employer-Sponsored Insurance
- Local Health Care Coverage Planning Grant
- Potential Individual Insurance Mandate (2010)

CHRONIC CARE MANAGEMENT

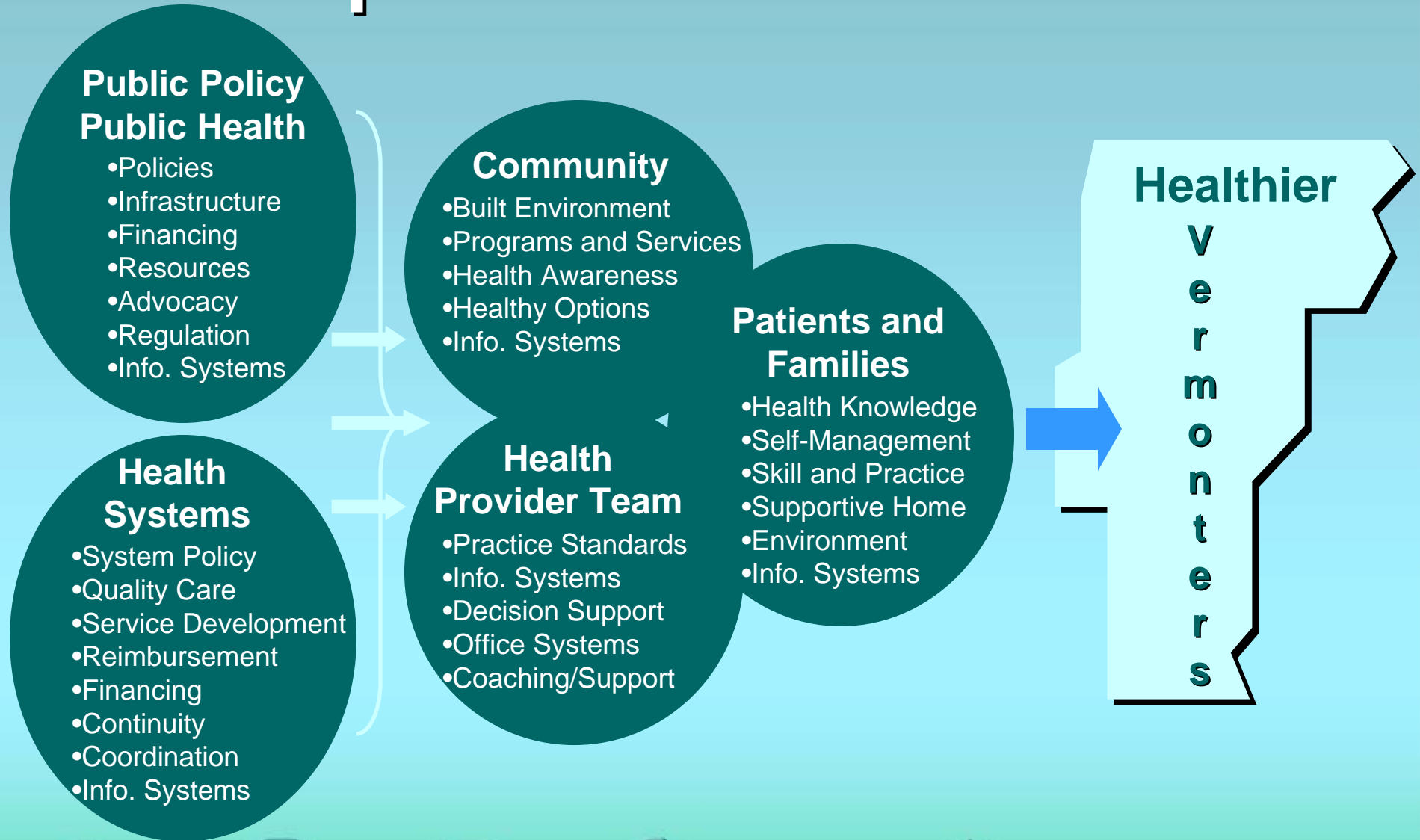
Chronic Care Strategies

- Blueprint for Health
- Medicaid Chronic Care Management Program
- Other Blueprint Alignments:
 - State Employee Health Benefit Programs
 - State-approved Employer-Sponsored Insurance (ESI) Plans for Premium Assistance
 - Catamount Health Plans
- AHS Implementation Plan for Prevention and Management of Chronic Conditions

Blueprint for Health

- State's Plan for Better Management and Prevention of Chronic Illnesses across All Payers and Providers
- Vision: *Vermont will have a standardized statewide system of care that improves the lives of individuals with and at risk for chronic conditions.*
- To achieve this vision, the Blueprint:
 - Utilizes a public-private partnership to facilitate and assure sustainability of the new system of care
 - Utilizes the Chronic Care Model as the framework for system change
 - Is the state's mandated standard for chronic care management across all payers and providers

Blueprint for Health Model



Examples of Blueprint Components

- Evidence-based standards for provider practices
- Patient self-management
- Community activation and support
- Information technology to support provider practice
- Investment in quality (e.g., pay for performance, financing for patient self-education, wellness activities)

OVHA Chronic Care Management Program (CCMP)

- Establish a Chronic Care Management Program (CCMP) for the Medicaid population.
- Contract with external vendors for two components:
 - Program intervention
 - Monitoring, evaluation payment

CCMP Interventions

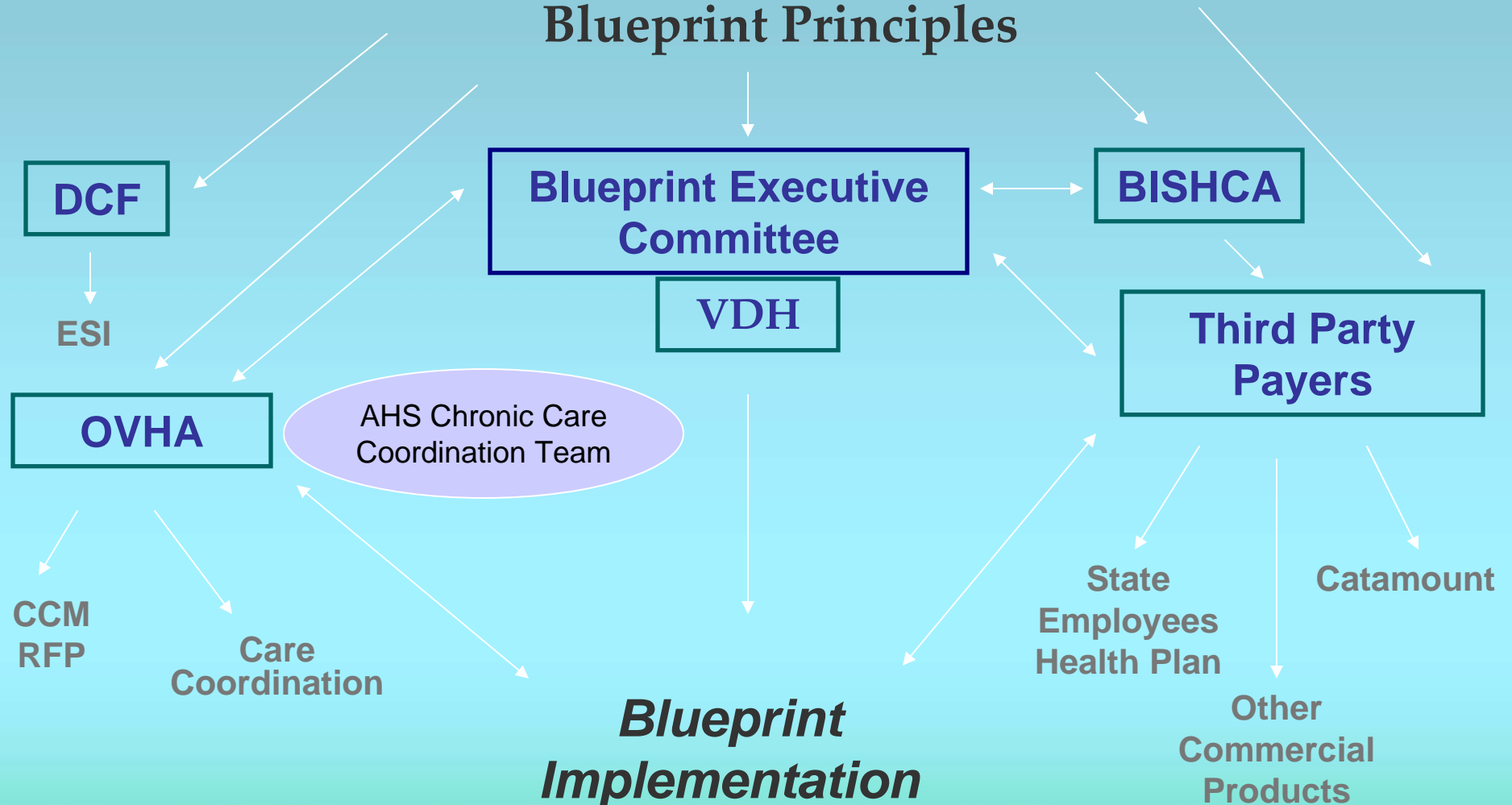
- Identify Medicaid enrollees with one or more chronic conditions (using claims data)
- Conduct health risk assessments (HRAs) for all beneficiaries identified
- Stratify the population into high, middle, low risk groups
- Conduct evidence-based care management interventions for each risk group (intensity varies by group)
- Coordinate CCMP activities with:
 - Care coordination program (coordinating the care needs of the 1-2% most complex Medicaid enrollees)
 - Blueprint for Health
 - Choices for care (Long-term Care Waiver)

CCMP Monitoring, Evaluation, and Payment

- Monitor implementation progress
- Evaluate vendor performance and program impacts (OVHA seeking consultant assistance)
- Conduct regular cycles of continuous quality improvement
- Make payment to vendor at financial risk for agreed-upon process and (ultimately) performance benchmarks

Blueprint Alignment

Blueprint Principles



Examples of Coordination

- All entities represented on Blueprint Steering Committee and work groups (self-management, community, provider practice, health systems and IT)
- Solicitation of input from VDH, Blueprint, BISHCA and Legislative Consultants on initial draft of OVHA Chronic Care Management RFP
- VDH and Blueprint sits on OVHA Chronic Care Management RFP selection process
- VDH Commissioner and Blueprint Executive Committee member involvement throughout the bidders' oral presentations, and best and final offer discussions for State Employee Health Plan
- On-going meetings of AHS Chronic Care Coordination Team

Blueprint Alignment Topics Across Chronic Care Programs

- Coordination of care across the multiple programs working with the same providers and patients
- Agreement on best practices for all chronic diseases
- Use of a consistent health risk assessment
- Referrals to patient self-management resources
- Coordination of IT initiatives to improve access and support clinical decision making
- Use of consistent metrics for provider feedback, profiling and measurement
- Changing fee structures to provide incentive to reward quality (e.g., pay-for performance)

Key Dates

- BLUEPRINT FOR HEALTH

October 1, 2006 Interim Revised Five Year Strategic Plan

January 1, 2007 Final Revised Five Year Strategic Plan

January 1, 2009 Statewide Blueprint Participation

- OVHA CHRONIC CARE MANAGEMENT PROGRAM

October, 2006 RFP Issued

July 1, 2007 Program Begins

Health Information Technology

- State Health Information Technology Plan (VITL)
 - Preliminary Plan by January, 2007
 - Final Plan by July, 2007
- VITL Medication History Pilot Project
 - Implemented at 2 sites by February, 2007
- Chronic Care Information System
 - Model fully designed by January 1, 2007
 - First community site (Mt. Ascutney) will be implemented in June, 2007
- Master Provider Index

PREVENTION

CHAMPPS (Coordinated Healthy Activity, Motivation and Prevention Programs)

- Competitive multi-year grants to communities starting July 1, 2007
- Projects must be:
 - Comprehensive approaches to promote healthy behavior and disease prevention
 - Across the community
 - Across the lifespan
 - Consistent with the Blueprint and community goals
 - Goal and outcome driven
 - Based on effective strategies
 - Able to provide data for evaluating and monitoring progress
- \$1,090,000 appropriated in FY07 (\$500,000 from federal substance abuse grant)

Healthy Lifestyles Insurance Discounts

- Permits BISHCA regulations to allow carriers to establish rewards, premium discounts, rebates, or waive/modify cost-sharing in return for member's adherence to programs of health promotion and disease
- Allows discounts of up to 15% of premium for compliance with health promotion program
- Limits total deviation from community rate to 30% (including these discounts) in the individual and small group insurance markets
- Rules developed by June, 2007
- Also allowed in Catamount Health plans

Other Prevention Initiatives

- AHS inventory of state wellness initiatives and funding
- Clinically recommended immunizations provided to all Vermonters at no cost
 - January 15, 2007 Report re: methods to ensure universal access to immunizations
- Catamount Health Plan: waiver of cost-sharing for prevention

Quality Improvement Initiatives

- Consumer Health Care Price & Quality System
- Multi-payer Database
- Hospital Adverse Events Monitoring System
- Hospital-acquired Infections Data
- Hospital Safe Staffing Reporting
- SorryWorks!
- Advanced Directives Registry, Forms and Stickers

Financing of Reforms

- Based on the principle that everybody is covered and everybody pays:
 - Catamount Health Plan: Individuals pay sliding scale premiums based on income
 - Employers pay an assessment based on number of uncovered employees (measured as full time equivalents), exempting eight FTEs in fiscal years 2007 and 2008, six FTES in 2009, and four FTES in and after 2010
 - Increases in tobacco taxes
 - VHAP savings due to Employer-Sponsored Insurance (ESI) enrollment
 - Savings due to better chronic care management
 - Matching federal dollars via Global Commitment 1115 waiver
- State fiscal obligations protected through possible caps on enrollment in premium assistance programs

Employer Contribution

- Seeks to equitably spread the costs of health care
- Assessment for “uncovered employees”
 - Employers without a plan that pays some part of the cost of insurance of its workers must pay the health care assessment on all employees.
 - Employers who have coverage must pay the assessment on:
 - ✓ Workers who are ineligible to participate in the plan
 - ✓ Workers who refuse the employer’s coverage and do not have coverage from some other source.

Employer Contribution

- Employee = any individual 18 years or older on employer's unemployment insurance filing *
- \$365 / year Fee per uninsured FTE (2007)
 - Assessed quarterly - \$91.25 / FTE / Qtr
 - FTE = number of employee hours worked during a calendar quarter divided by 520 (based on 40 hour work week maximum)
 - Exempts 8 FTEs in 2007 & 2008; 6 FTEs in 2009; 4 FTEs thereafter
- Annual Fee indexed to Catamount Health premium increases
- Assessment is NOT a premium; does NOT enroll employees in Catamount Health!

* Seasonal /Temporary Employees currently included; report with options due to Legislature in January, 2007

Key Dates

■ EMPLOYER CONTRIBUTION

September, 2006 Draft Rules Distributed for Public Comment

December 13, 2007 Final Rules Approved

January 15, 2007 Report on Inclusion of Seasonal Employees

April 1, 2007 Assessment Implemented (to be paid at end of 4th Quarter – June 30, 2007)

Strategies to Address Cost Shift

- Medicaid Rate Increases for Primary Care Providers, Hospitals and Dentists (January 1, 2007)
- Cost Shift Task Force
- Hospital Cost Shift Reporting Reforms
- Standardized Policy for Hospital Uncompensated Care and Bad Debt

Key Dates - Other Initiatives

- December 1, 2006
 - Cost Shift Task Force Report
 - Medicaid Outreach Report
- January 1, 2007
 - Standardized Uniform Provider Credentialing in Use
- January 15, 2007
 - Medicaid Deficit & Reimbursement Study Report (HAOC)
 - Common Claims Procedures Interim Report
 - Recommendations for Standardized Hospital Uncompensated Care & Bad Debt Policy
 - Master Provider Index Report
 - Non-Group Market Consolidation Report

Key Dates - Other Initiatives, *cont.*

- April 30, 2007
 - Consumer Price and Quality Information System Rules
 - Change Hospital Reporting Requirements for Cost Shift Information, Hospital–Acquired Infection Rates, and Nurse Staffing Measures
- June 30, 2007
 - Adverse Events Monitoring System Rules
 - Local Health Coverage Planning Grant Issued
- January 15, 2008
 - Common Claims Procedures Final Report
 - Adverse Events Monitoring System Interim Report
- January 15, 2009
 - SorryWorks! Implementation Report on Pilot Program
 - Adverse Events Monitoring System Final Report

Key Dates - OVERSIGHT

- Reports on Reform Progress

December 1, 2006

- Five-year plan for Health Care Reform Implementation, including recommendations for administration or legislation

January 15 annually

- Administration Report on Reform Progress

- Universal Coverage/Individual Mandate - 2011

- If Vermont has less than 96% of the population insured in 2010, Health Care Reform Commission must submit a plan to increase health care coverage to ensure universal access, including individual mandates

Opportunities for Transferability

- Make health care affordable and accessible to uninsured
- Manage and coordinate chronic care for all
- Build on Employer-Sponsored Insurance (ESI)
- Outreach to Medicaid eligible uninsured
- Reduce cost shift by:
 - Insuring the currently uninsured and reimbursing at 110% of cost
 - Providing better chronic care
 - Increasing Medicaid reimbursement
- Finding common ground: building broad based coalitions